Integration of Reproductive Health and Family Planning Services into Health and Non-Health Programs

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Expanding family planning and reproductive health services in Africa

Integration of Reproductive Health and Family Planning Services into Health and Non-Health Programs

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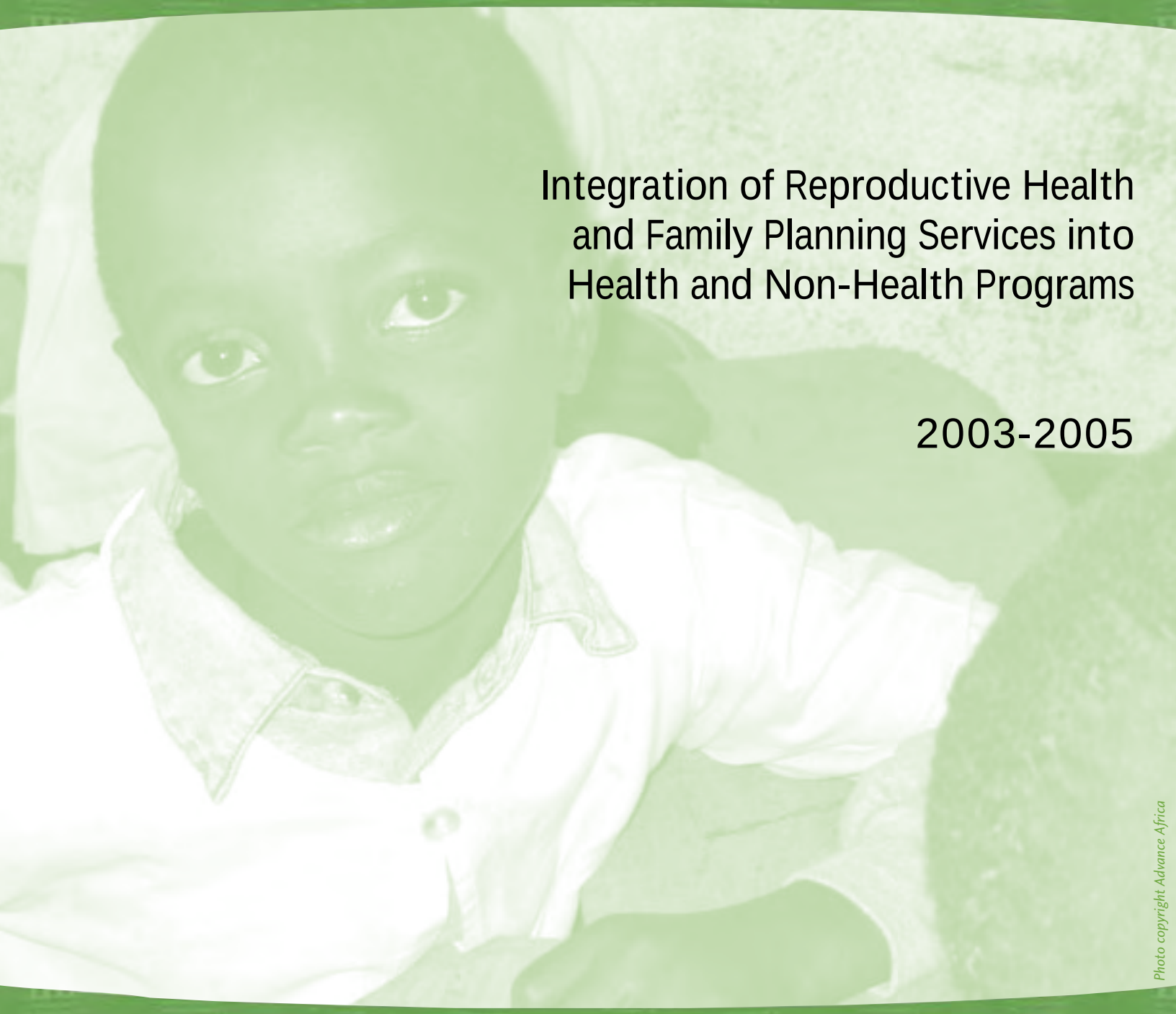

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Integration of Family Planning with Other Health and Non-Health Activities: HIV/AIDS, Life Skills Education, Conservation

End of Project Report
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Advance Africa Project

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
ARH	Adolescent Reproductive Health
CAs	Cooperating Agencies
CAFS	Centre for African Family Studies
CBDs	Community Based Distributors
CTA	Call to Action programme
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FAWE	Forum of African Women Educationists.
FGC	Female Genital Cutting
FHI	Family Health International
FP	Family Planning
HIV	Human Immunodeficiency Virus
LSE	Life Skills Education
MCH	Maternal and Child Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTCT	Mother to Child Transmission
IEC	Information, Education and Communication
PLP	Population Leadership Programme
PMTCT	Prevention of Mother to Child Transmission
PRA	Participatory Rapid Appraisal
PSI	Population Services International
QA	Quality Assurance
RH	Reproductive Health
SSA	Sub Saharan Africa
TA	Technical Assistance
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

Executive Summary

The Advance Africa global strategy for repositioning FP in Africa is a multifaceted approach that includes various types of specific interventions. Demonstration programs are an integral part of the approach and were designated in most cases to ensure an integration of FP activities to health and non health settings or to launched FP programs in post conflict settings. These demonstration programs have been among the most important component of the repositioning FP initiative. The demonstration projects established or strengthened family planning services through integration of family planning with health and non-health services, including HIV/AIDS, life skills education, and environmental conservation. Upon successful implementation, the results of the investment in these demonstration projects were used to strengthen advocacy for family planning as a health and development intervention and sparked USAID Mission commitment to family planning programming.

These demonstration programs were implemented in the post-conflict or economical crisis context in Angola, DRC and Zimbabwe. The intension was to show how much FP, as a preventive measure can contribute to strengthen or rebuild health systems in difficult conditions. The needs for FP in these post-conflict and crisis contexts are great. When rapidly addressed by involving the communities, FP can become a starting point or a consolidating mechanism for reinforcing the implementation of other interventions. Women and families in those very difficult environments are doing everything they can for their survival, and usually do not want to have children. The desire not to have children is especially strong during the critical phase of the rehabilitation and relief period. So, the need for FP is great even if not well express because of ignorance of existing methods and ways to access them. Family Planning can be a strong integrating factor, that links people, creates hope, liberates them from various burdens, and consequently facilitates the rebuilding effort.. The messages used to inform and sensitize people in the value added of Family Planning in the demonstration programs focused on the health and social benefits of contraceptives methods used for longer birth intervals and delaying sex debut. The preliminary results achieved were very encouraging and widely used in advocacy efforts to bringing back FP as a priority health and development intervention.

FP/HIV/AIDS Integration

Implementation of demonstration projects such as the integration of family planning with prevention of mother-to-child transmission (PMTCT) was one means by which to demonstrate the effectiveness of family planning as a health intervention. Integration of these two services is taking place in the context of high HIV prevalence in Sub Saharan Africa, 7.4% on average (UNAIDS, 2004), and low contraceptive prevalence rates, 20% for modern methods (UNFPA, 2004).

Prior to implementation of activities, Advance Africa and the Catalyst Consortium conducted a survey that sought to document existing family planning and HIV integration activities that were being undertaken by cooperating agencies (CAs) globally. This survey enabled the project have a better sense of the scope of integration activities and particular areas of focus. A detailed report of the survey was produced and results presented to the USAID FP/HIV Interagency Working Group.

In addition, a background paper on technical and programmatic issues related to integration of family planning and PMTCT was also developed to provide guidance to organizations on integration. It discussed the specific issue of prevention of unintended pregnancies as a way of averting vertical transmission of HIV and the need to promote dual protection. It also discussed the issue of optimal location of family planning services within existing service delivery institutions. The background paper drew attention to the challenge of capacity building and provision of adequate guidelines on the safe and effective contraceptive methods for HIV+ women. The two documents were widely distributed among USAID, local partners, CAs, and other government agencies.

Based on this work, the project then developed a strategy for implementation of family planning and HIV, specifically PMTCT. The guiding principles of the strategy included the use of existing PMTCT and PMTCT-Plus programs and the formalization of integration as a way of providing family planning as part of a larger care and support portfolio for HIV+ women. Broad strategies included advocacy, demand creation, capacity building and monitoring and evaluation. Specific proposals were developed for different institutions after which detailed assessments were made including community assessments. The community assessments in particular were to assess linkages between communities and the hospitals and how demand for services would be created and sustained. Based on these assessments, detailed plans were developed using a participatory approach with the relevant institutions.

Advance Africa went on to implement FP/HIV integration activities in partnership with the Lusaka District Health Management Board in Zambia, three mission hospitals in Zimbabwe, and 10 provincial directorates from the Ministry of Health (MOH) in Mozambique. The objective was to demonstrate the feasibility of integration as a means of reducing vertical transmission of HIV and meeting the family planning needs of PMTCT and HIV+ clients.

A curriculum was developed to train health workers in various institutions. The 5-day training focused on the theory of integration with a specific focus on the special contraception needs of HIV+ women. Detailed attention was paid to addressing myths and misconceptions about contraception in HIV + women. Emphasis was also placed on the promotion of dual protection. In all, a total of 69 nurses and midwives were trained. The nurses and midwives came from selected facilities in Zambia, Zimbabwe, and Mozambique.

Some outputs of the process include the following:

- Training curriculum
- Framework for monitoring
- FP/HIV Integration advocacy poster (specific to Zimbabwe but adaptable for other countries)

Uptake of contraceptives has been consistent in all the sites among both new and continuing clients. The methods that are most popular are not consistent across all sites but appear to be related to what was previously promoted in the given site. In Zimbabwe, for instance, implants were quite popular at Howard Hospital whilst they were rarely used at Tshelayemba Hospital.

Lessons learned include a need for aggressive advocacy for integration, the need for providing clear guidelines on implementation, and a thorough training for providers to allay misconceptions.

Life skills Education among Adolescents

Advance Africa's adolescent reproductive health (ARH) and life skills education (LSE) program was conducted in collaboration with a consortium partner, the Forum for African Women Educationalists (FAWE). Activities consisted of three components, each targeting a different level:

1. Regional awareness and capacity-building on ARH issues for designated FAWE chapters
2. FAWE chapter-specific strategy development
3. FAWE chapter country program implementation in Senegal, Zimbabwe, and Mozambique

In the first two years of the Advance Africa project, the FAWE headquarters in Nairobi provided support for these efforts. A needs assessment was conducted to identify priority areas, levels of knowledge and skills in ARH, and access to services and information in various FAWE activities and girls clubs. Questionnaires from the Anglophone and Francophone chapters were completed and analyzed for use in the curriculum design workshop. Members of the FAWE Regional Secretariat, two FAWE country chapters, and the Centre for African Family Studies (CAFS), with technical assistance from Advance Africa, jointly held a workshop to develop the curriculum for the training of trainers (TOT) in ARH. The ideas developed in that workshop were then used by Advance Africa to develop the "Life Skills Education" (LSE) training curriculum for two TOT workshops that took place in Harare, Zimbabwe, and Dakar, Senegal. LSE includes information about abstinence, delayed sexual debut and optimal birth spacing of 3 to 5 years, with education on the risks of teenage pregnancy and short birth intervals. The joint planning and execution of a regional FAWE TOT workshops marked the beginning of capacity-building activities at the national level where 36 trainers were trained from Burkina Faso, Cameroon, Kenya, Mali, Namibia, Senegal, Togo, Zambia, and Zimbabwe.

Following the regional training, Advance Africa formed partnerships with specific FAWE chapters in Mozambique, Zimbabwe, and Senegal where Advance Africa had existing program activities. The FAWE chapter in Senegal developed an innovative approach to integrating female genital cutting (FGC) prevention and LSE into the education system that covered 6 regions in the country and more than 20,000 adolescent girls and boys.

The work of FAWE in Mozambique and Zimbabwe also included TOT in LSE. The Zimbabwe and Mozambique chapters (FAWEZI and FAWEMO respectively) reviewed and adapted various modules and strengthening participatory learning tools. Pre- and post-training questionnaires were developed. All training activities were not completed due to the early closure of the project in the implementing countries. Advance Africa has, however, provided the FAWE chapters the necessary basic skills to develop follow-up plans to pursue this important ARH activity after Advance Africa support has ended.

Integration of Family Planning and Environmental Conservation
Advance Africa collaborated with the Jane Goodall Institute (JGI), whose mission is to "advance power of individuals to take informed and compassionate action to improve the environment of all living things." The collaboration was designed to integrate FP activities into JGI's conservation program in DRC. This collaboration supported Advance Africa Intermediate Result # 3 : "improve intersectoral collaboration, linkages and integration of RH/FP with health and non-health programs". The Jane Goodall Institute implements along the Congo River basin a conservation program based on the experience gained from a similar intervention conducted in Tanzania, named TACARE (Lake Tanganyika Catchment Reforestation and Education). The DRC activity focuses mainly on combining FP services with conservation activities so that the population will better understand the real sense of their mutual beneficial linkage.

1. Integration of Family Planning and HIV/AIDS Programs

A. Introduction
The overall strategic objective of Advance Africa project is to "increase the use of sustainable, quality FP/RH services and healthy practices through clinical and non-clinical programs." One of the two strategic areas of Advance Africa's program is the repositioning of family planning in sub-Saharan Africa. A number of interventions were undertaken to accomplish this. The range of interventions included policy dialogue with relevant institutions, innovative technical approaches, partnerships, and the implementation of demonstration projects both in health and non-health sectors.

A challenge for repositioning family planning, however, has been that family planning has been presented as a means to simply control the world's population size for decades. The current global situation, particularly in sub-Saharan Africa, requires a different approach. With the dramatic reduction in the world's population growth rates—due in part to lower fertility in some regions and to higher mortality caused by HIV/AIDS and other infectious diseases—family planning must be considered a *health and development intervention*, and not simply a means of population control. Advance Africa and other family planning groups across the globe must enhance decision makers' appreciation of family planning in this capacity and work to reposition family planning in this new light.

In addition to increasing the general population's ability to space births and plan their families, Advance Africa focused on enhancing family planning services for specific populations, such as people living with HIV/AIDS (PLWHA). Because HIV/AIDS is an issue throughout sub-Saharan Africa (SSA), it is important to understand the family planning needs of people living with HIV/AIDS.

Integration has been identified as the central point around which all interventions aimed at accomplishing the strategic objective should revolve. This implied that both short- and long-term technical assistance (TA), demonstration projects, as well as the use of project tools, such as Strategic Mapping and the Best Practices Compendium, should all be geared towards integration of FP into other health and non-health interventions.

The areas of focus included the integration of family planning counseling, services, and referral within voluntary counseling and testing (VCT) and PMTCT programs as well as social mobilization and support for those who have tested positive upon return to their communities. Within the global strategy, Advance Africa implemented demonstration projects that will increase access to family planning services for PLWHAs specifically, and others seeking HIV/AIDS-related services in general. The integration efforts were implemented in Mozambique, Zambia and Zimbabwe.

The objective of the FP/HIV integration effort was to demonstrate the feasibility of integrating family planning into VCT/PMTCT services as a means to reducing vertical transmission of HIV within selected PMTCT and PMTCT-Plus programs in Africa

B. Activities

i. Survey on FP/HIV Integration

In order to have a sense of what had already been going on in the area of integration, Advance Africa conducted a joint survey of CAs' FP/HIV integration activities in collaboration with the CATALYST Consortium. The survey was meant to provide insights into the status and range of activities related to dual protection and integration of family planning and HIV/AIDS undertaken by CAs globally.

The survey found that USAID had injected over $200 million into dual protection and integration activities over a four year period (1998 – 2001) while other donors had contributed another $125 million. It also showed that many integration programs were working with the general population through services such as MCH but not targeting high risk groups. The majority of integration efforts were promoting dual protection with condoms and not condoms with other methods.

Most integration and dual protection projects were being implemented in Africa, the region most affected by HIV/AIDS. Many fewer were being implemented in Asia and the Near East and Europe and Eurasia, two regions where HIV infection rates are beginning to soar. As of spring 2002, most projects focused their work on communication, training, and education, with much less attention to strategies such as voluntary counseling and testing, prevention of mother-to-child transmission, and generating policy. Activities were also found to be bi-directional with family planning integration into HIV and HIV integration into family planning.

This paper was widely distributed in countries where integration was to be implemented, and was also available on-line for other partners in integration. See Annex 1 for the executive summary of the survey.

ii. Issues Paper

An issues paper, *"Family Planning and the Prevention of Mother-to-Child Transmission of HIV: Technical and Programmatic Issues,"* was developed to thoroughly explore integration issues.

This paper, among others, stressed the fact that the discussion around FP/HIV integration has so far focused on dual protection among HIV-negative women but not on prevention of future pregnancies in women who are already infected. The paper also underscored the need to consider a whole range of issues such as the complexity of the circumstances within which HIV-positive individuals, especially women, find themselves and which make decisions about family planning difficult.

The discussion called for the provision of guidelines on contraceptive methods that are safe for use by HIV-positive women. Some programmatic issues raised in the paper included the optimal location for family planning services, assuring post-natal follow up and capacity building among staff and facilities to effectively undertake FP/HIV integration. This is a very useful resource that gives a concise overview of some of the issues that need to be considered in the planning and implementation of any integration program. This is a concrete manifestation of the leadership role of Advance Africa in integration of family planning and PMTCT.

iii. Strategy Development

A global strategy for integration of family planning and PMTCT was developed, out of which specific proposals for the different Advance Africa integration sites were developed. The two reports described above were used in addition to other reference materials as a basis for the development of the strategy and subsequently detailed implementation plans. This strategy gave rather broad principles of integration and a framework for the implementation and monitoring of activities.

The key areas in the strategy included the following:

- The introduction covered the burden of reproductive health and HIV/AIDS with particular reference to PMTCT in Africa. This was to set the tone for the justification of integration.
- The guiding principles combined the use of existing PMTCT and family planning programs with working programs to formalize integration, capacity for sustainability, and provision of family planning as part of the larger care and support for HIV-positive individuals and their families.
- The development of broad strategies for advocacy, demand creation, training, capacity-building of national PMTCT teams, and TA for implementation. The TA covered logistics management, supervision, and data management.
- Indicators and results to be monitored were outlined.

iv. Columbia University PMTCT-Plus Integration Proposal

A proposal for the integration of family planning into Columbia University's PMTCT-Plus Program was developed and shared with USAID and Columbia University. The key elements of the proposal included a five step approach of: 1) rapid assessment of proposed sites, 2) participatory planning, 3) training, 4) strengthening health center management, and 5) monitoring of provider competencies as a way of ensuring effective implementation. Several key results were monitored: the increase in number of PMTCT clients using contraceptive methods

in general by HIV status, and the proportion using long-term methods (as the latter is a more effective way of averting vertical transmission of infected women to their children). As the proposal delineated management arrangements, there was not a separate MOU developed.

The innovative strategy incorporated the following:

- *Adaptation of the global strategy to suit local circumstances.* An adaptation of Strategic Mapping was used that facilitated a participatory rapid assessment, after which participatory planning with all key stakeholders took place. The planning was focused on responding to gaps identified in the rapid assessment.
- *Activities to reinforce and facilitate post-natal care.* An expanded role was developed for community-based distributors (CBDs) and hospital-based community outreach teams. These providers were oriented to provide adequate information to community members to facilitate the uptake of post-natal care in which discussions of family planning would take place. Resources were made available to ensure that CBDs and clinic outreach staff could actually reach out to people in the communities.
- *Improved access to long-term methods.* This was to be accomplished by providing long-term methods at a reduced cost or for free where clients were unable to afford them.
- *Strengthened technical supervision.* The use of supervisory checklists that focused more on provider competencies than management indicators was introduced.
- *Designated focal point as liaison between clinics and communities.* This link ensured the continuous dialogue that would facilitate uptake of family planning.

v. Site Assessments

Prior to the actual implementation of integration activities, all proposed sites were assessed. Each assessment covered the current status of FP/RH and PMTCT, with specific reference to opportunities that could be utilized to provide family planning information. They explored human and other resources that were available and how they were being managed. They also identified gaps needed to be addressed to ensure effective integration. Situations were identified that could be used to reduce missed opportunities in the provision of family planning information and/or services. In Zimbabwe, community assessments documented resource opportunities and threats to integration.

vi. Advocacy Seminar

In preparation for the implementation of integration activities in Zimbabwe, a one-day seminar on integration of family planning and HIV programs was organized in Harare on 16 September 2003. The seminar attracted participants from the MOH, USAID, and other CAs working in PMTCT, as well as representatives of three mission hospitals where integration was to be implemented.

Some of the topics covered at this meeting included the rationale for FP/HIV integration, Advance Africa's strategic approach to integration, and lessons learned from Kenya in the integration of family planning and VCT. The seminar also discussed challenges for implementation and the possible means to resolve them with resource persons from Advance

Africa, Population Services International (PSI), and Family Health International (FHI). The seminar was very successful in that it provided an opportunity to discuss the issue of integration and solicited views on the best approach to integration in Zimbabwe within the current context and constraints in resources.

Another product of this seminar was the formation of a country working group on integration that was charged with following up on the effective implementation of integration in the country. This group, facilitated by Advance Africa, was also to oversee the conduct of a study by FHI to document family planning in the era of HIV/AIDS in Zimbabwe as part of a five country survey.

In addition to building the capacity of partners in understanding the issues around integration, it also showcased the inter-sectoral collaboration that is so crucial in the integration of family planning and HIV/AIDS.

vii. Field Assessments

Following the selection of sites for integration both for the Columbia University sites (two) and in Zimbabwe (three), initial visits were made to determine feasibility and solicit concurrence with the various sites. Afterward, detailed assessments were conducted in all but the Columbia site in Mozambique. The assessment used a modified version of the Strategic Mapping tool. Areas covered in assessments, making use of literature reviews, interviews, and observations where feasible, included the following:

- An overview of the FP/RH status in the country as a whole and in the particular site and its environs
- The status of PMTCT/PMTCT Plus
- A description of availability of services: hours of operation, staffing, logistics, etc.
- Issues of access including financial and socio-cultural dimensions
- Current demand for services as a way of anticipating demand creation strategies
- Quality of services as related to human capacity and availability of quality assurance systems
- Sustainability, especially in terms of whether there are plans for the country to scale up integration and what preparatory steps have included

The key findings from these assessments formed the basis of the participatory development of detailed implementation plans with all relevant stakeholders for the sites where the assessments completed. This approach created a sense of ownership in the integration sites. It also enabled the design of a plan that would not undermine current service delivery arrangements.

viii. Development of Detailed Implementation Plans

Based on the assessments, detailed implementation plans were developed for each of the mission hospitals in Zimbabwe as well as Chelston clinic in Zambia. The plans were budgeted and grants prepared to enable implementation, which started between June and August 2004.

ix. FP/HIV Integration Training Curriculum

In Zimbabwe, Advance Africa developed and pre-tested a curriculum that merged modules for the rationale and principles of integration with technical details of family planning for HIV-positive individuals. The five-day training curriculum is made up of six modules focused on reviewing the burden of HIV and family planning in Africa as well as unmet need for family planning. It articulates the model for PMTCT and the missing WHO prong of "prevention of unintended pregnancies." The rationale for integration is stressed in the curriculum and covers models for integration in terms of service delivery arrangements.

The family planning modules cover definitions of family planning and demography, anatomy and physiology of the male and female reproductive systems, and communication skills required for family planning conversations with clients. Other topics covered include client screening including history-taking and examination; introduction to contraception, which details various contraceptive methods; and data management. The curriculum also emphasizes special attention to infection prevention in all actions whilst examining or providing any contraception to HIV-positive clients in particular because of their increased vulnerability to infections.

The document went through extensive review and a final draft is available. As this curriculum was tailored specifically to Zimbabwe, it may have to be adapted for a more generic use.

x. Training

Training was part of the rapid assessment of integration sites. As a result, the training needs of various staff were identified and the numbers to be trained were determined.

Three categories of staff were identified to benefit from training, including nurses, midwives, and their supervisors who will provide direct services; other nursing staff who may not directly provide services but can facilitate uptake through referrals and advocacy; and the other non-clinical staff who will be oriented to family planning for services knowledge and promotion. Some of the initial group of trainees was also to serve as supervisors for others and to support training of other staff in the future. This will ensure that skills are transferred and will remain in the clinics for use in the future.

C. Results

a. Outputs

- Report: *Analysis of Family Planning / HIV/AIDS Integration Activities within the USAID Population, Health and Nutrition Center*
- Report: *FP/PMTCT Integration: Technical and Programmatic Issues*
- FP/HIV Integration Training Curriculum
- Advocacy Poster (specific for Zimbabwe but applicable elsewhere)
- Detailed Implementation Plans for each hospital/clinic
- Monitoring Framework

b. Outcomes

The number of health care workers trained in each facility:

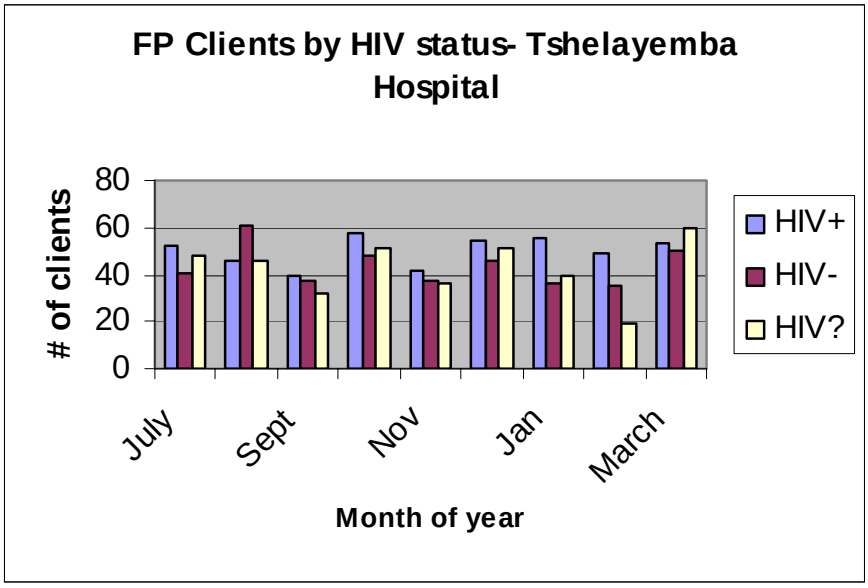
Howard Hospital, Zimbabwe	5
Gutu Mission Hospital, Zimbabwe	5
Tshelayemba Hospital, Zimbabwe	6
Chelston Clinic, Zambia	25 (5-day training)
	25 (2-day orientation)
Mozambique	28 trainers for the ten provinces

c. Uptake of Family Planning among PMTCT Clients

Table 1. Family Planning Clients (new and continuing) by HIV Status – Tshelayemba Mission Hospital, Zimbabwe

Month	HIV+	HIV-	HIV?	Total
July 2004	52	41	48	**141**
Aug 2004	46	61	46	**153**
Sept 2004	40	37	32	**109**
Oct 2004	58	48	51	**157**
Nov 2004	42	37	36	**115**
Dec 2004	54	46	51	**149**
Jan 2005	56	36	39	**131**
Feb 2005	49	35	19	**103**
Mar 2005	53	50	60	**163**

Figure 1. Family Planning Clients by HIV Status, Tshelayemba Hospital, Zimbabwe



While there is no clear trend as to the total number of clients, it is clear that the opportunity is being provided attendees at the PMTCT service to access family planning. This will reduce

unmet need and improve contraceptive prevalence in the long term. It will also improve the health of affected mothers and their other children

Table 2. New FP acceptors (HIV+) by month
Tshelayemba Hospital, Zimbabwe

Month	**# of clients**
July 2005	25
Aug 2005	27
Sept 2005	28
Oct 2005	31
Nov 2005	24
Dec 2005	25
Jan 2005	37
Feb 2005	47
Mar 2005	23

The general trend in family planning uptake for new clients who are HIV+ is increasing. Ensuring that these clients continue to use contraceptive methods over a prolonged period of time will be needed.

Table 3. Family Planning Clients (new and continuing) by HIV status
Howard Hospital, Zimbabwe

	HIV+	**HIV-**	**HIV?**	**Total**
Oct 2004	54	20	228	**302**
Nov 2004	69	102	508	**679**
Dec 2004	106	43	360	**509**
Jan 2005	424	3	581	**1008**
Feb 2005	330	166	728	**1224**
Mar 2005	90	81	452	**623**

There appears to be an upward trend in the number of HIV+ clients in particular receiving contraceptives over time. The numbers of clients with unknown HIV status also shows an increase over time. Therefore, it is necessary to intensify education on voluntary testing to ensure that such clients get to know their status and are counseled accordingly.

Table 4. New FP acceptors (HIV+ clients) by month
Howard Hospital, Zimbabwe

Month	# of new HIV Clients
October 2004	54
November 2004	69
December 2004	106
January 2005	69
February 2005	310
March 2005	90

There is a general upward trend for the uptake of family planning among HIV positive clients at Howard Hospital. This is a positive sign that would allow the programme to provide adequate counseling on sustained family planning usage.

Figure 2. ***New FP acceptors at VCT sites constitute a high proportion of all FP users.***
New Family Planning Acceptors, Tshelayemba and Howard Hospitals, Zimbabwe.

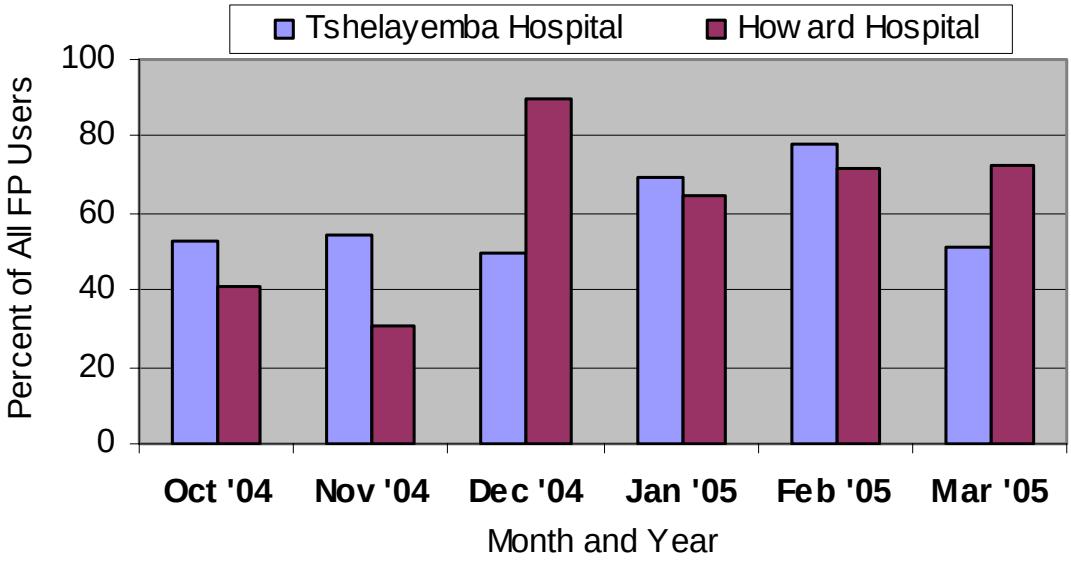


Figure 3. ***With increased awareness of the benefits of FP and knowledge of HIV status, many HIV-positive clients become new FP users, potentially averting vertical infection.***
HIV+ Clients – New Family Planning Acceptors, Tshelayemba and Howard Hospitals, Zimbabwe.

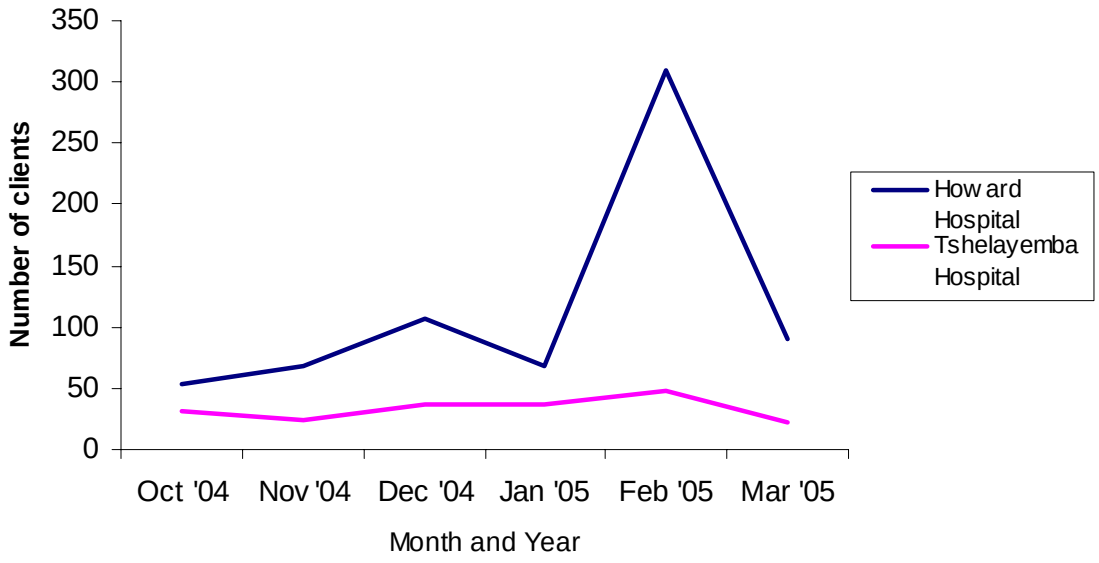
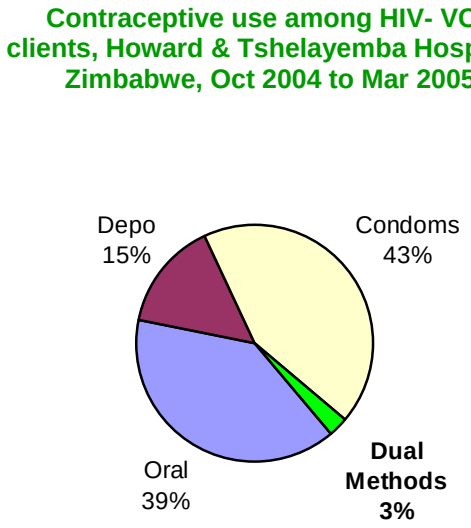


Figure 4. ***HIV+ clients are using dual methods more than HIV- clients, thus preventing partners from becoming infected.*** **Method Mix, HIV- and HIV+ Clients, Tshelayemba and Howard Hospitals, Zimbabwe.**



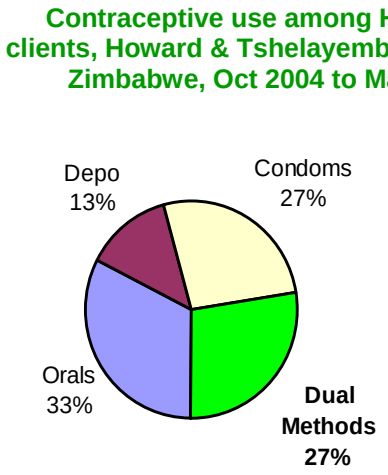


Table 5. Family Planning Uptake by HIV status
Chelston Clinic, Lusaka, Zambia

Month	HIV+	HIV-	HIV?	Total
October 2004	93	26	7	**126**
November 2004	48	149	132	**329**
December 2004	124	70	0	**194**
January 2005	99	70	0	**169**
February 2005	44	19	0	**63**
March 2005	253	96	239	**588**

There does not appear to be any specific pattern to family planning use over time at Chelston Clinic. It is however worthy of note the fact that clients at PMTCT services are accessing family planning services. This will be a way to enhance contraceptive prevalence in the district in addition to preventing unintended pregnancies in HIV+ women.

Figure 5. Family Planning Update, Chelston Clinic, Zambia

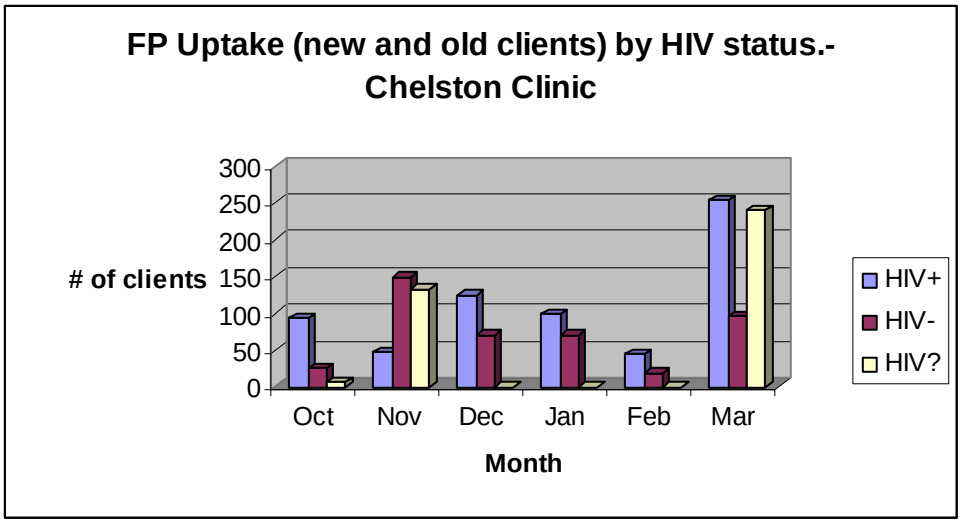
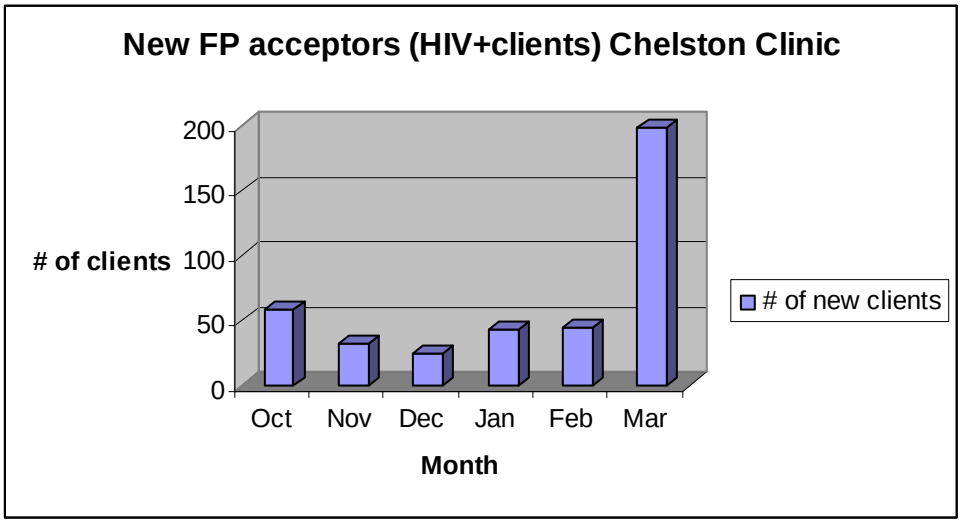


Table 6. New Family Planning Acceptors (HIV+ clients) by month
Chelston Clinic, Lusaka, Zambia

Month	# of new clients
October 2004	58
November 2004	32
December 2004	25
January 2005	43
February 2005	44
March 2005	198

At Chelston Clinic, while there was a downward trend to family planning use among new acceptors for the first three months, the use increased again over the ensuing months with a dramatic increase in March 2005.

Figure 6. New Family Planning Acceptors, Chelston Clinic, Zambia



D. Lessons Learned from the Integration of Family Planning and PMTCT

1. Integration in principle is accepted as a way of making the most efficient use of limited resources within the reproductive health sector. However, as there is often a reluctance to change, there is still a tendency for programs to remain vertical for several reasons. In order for integration to be institutionalized and made more effective, a lot of advocacy is required at all levels. Program managers must take advantage particularly of the global drive to integrate HIV/AIDS and FP/RH programs.

2. Trying to accomplish the objectives of a centrally-funded USAID project and the specific objectives of USAID Missions concurrently remains a big challenge.

3. There is a need for clear guidance in the implementation of integrated services, particularly FP/PMTCT. This guidance needs extensive dissemination to ensure training and awareness among appropriate staff.

4. Capacity building is crucial and training needs will have to be carefully assessed for different cadres of health care workers.

5. Models for integration will differ from setting to setting, and therefore there is a need for flexibility in implementing integration of family planning and HIV/AIDS activities.

6. Working with different partners with varying agendas is not easy. However, the goodwill for integration among partners is an opportunity that should be pursued.

E. Recommendations

Aggressive advocacy at all levels, especially starting from the policy levels, needs to be in place to ensure the smooth implementation of integration. This will ensure adequate financial and other provisions made for integration and that funding decisions are not left to the discretion of partners.

A systematic approach to the dissemination of integration guidelines produced by the USAID Integration of FP/HIV Interagency Working Group needs to be put in place to ensure that all relevant partners get adequate information to influence their decisions on integration programming.

USAID/Washington should facilitate USAID Mission buy-in for implementation of integration activities using core funding.

Best practices of successful integration initiatives should be widely publicized among all potential partners in integration.

F. Conclusion

Integration being a key strategy in the achievement of Advance Africa's results was pursued within a variety of initiatives. Even though the ultimate results in the increase in numbers of acceptors of family planning may be limited due to the short implementation period, the ground has been prepared for such results to be accomplished in the coming months. Advance Africa has demonstrated its role in leadership as well as capacity building and provision of tools for scaling up of integration as a strategy to repositioning family planning in Africa.

Advance Africa has faced and resolved challenges in implementing FP/HIV integration. With the support and cooperation of all stakeholders, the ultimate goal of increasing the use of sustainable quality family planning services in Africa will be accomplished.

2. Integration of FP/RH with Life Skills Education for Adolescents

A. Introduction

FAWE is a pan-African organization established in 1992 with representation in 33 countries in Africa. The basic objective of the organization is to encourage the girl child to go to school and to achieve socio economic success in future. Advance Africa worked with FAWE to integrate ARH and LSE through three activities, each targeting a different level:

- Regional awareness and capacity building on ARH issues for designated FAWE chapters
- FAWE chapter-specific proposal development strategy
- FAWE chapter country program implementation in Mozambique, Senegal, and Zimbabwe

Objectives

1. To integrate adolescent reproductive health (ARH) and life skills education (LSE) into the educational sector via schools, FAWE girls' clubs, and other youth-oriented venues in Mozambique and Zimbabwe.

2. To contribute to the national objective of eradicating Female Genital Cutting (FGC) by effectively involving networks of FAWE centres of excellence and teachers of life and earth sciences in Senegal.

B. Activities

i. Training Needs Assessment

In the first two years of the Advance Africa project, the FAWE headquarters office in Nairobi provided support for these efforts. A needs assessment was conducted to identify priority areas, levels of knowledge and skills in ARH, and access to services and information in various FAWE activities and girls clubs. A total of 13 questionnaires from the Anglophone chapters and 12 from the Francophone chapters were completed and analyzed for use in the curriculum design workshop.

ii. Curriculum Development and Training of Trainers

Members of the FAWE Regional Secretariat, two FAWE country chapters, and CAFS acting as Chief Trainers, with technical assistance from Advance Africa, jointly held a workshop to develop the curriculum for the training of trainers (TOT) in ARH in Nairobi, 24–28 February 2003. The ideas developed in that workshop were then used by Advance Africa to develop the LSE training curriculum for two TOT workshops that took place in Harare, Zimbabwe, and Dakar, Senegal, in March and April 2003. The LSE curriculum includes information about abstinence, delayed sexual debut, and optimal birth spacing of 3 to 5 years along with the risks of teenage pregnancy, short birth intervals, and sexually transmitted infections (STIs). The joint planning and execution of a regional FAWE TOT marked the beginning of the capacity-building activity at the national level, and 38 trainers were trained.

iii. Partnerships with Specific Country Chapters

Following the regional training, Advance Africa formed partnerships with specific FAWE chapters in Mozambique, Zimbabwe, and Senegal. The FAWE chapter in Senegal developed an innovative approach to integrating FGC prevention into the educational system that covered six regions in the country and more than 20,000 adolescent girls and boys. FAWE Senegal has already completed the implementation of its program and the results are currently being evaluated.

The work of FAWE in Mozambique and Zimbabwe also included the LSE program TOT. The Zimbabwe and Mozambique chapters finished reviewing and adapting various modules,

strengthening participatory learning tools, and identifying appropriate trainers and selection criteria for TOT participants.

iv. Specific country activities

Mozambique

FAWE/ Mozambique (FAWEMO) completed a training of trainers for their life skills education programme. FAWEMO conducted the training on 21-30 July in collaboration with and under the oversight of the MOH and Ministry of Education. The training for 30 participants took place in Maputo and included teachers from Maputo, Cabo Delgado, Nampula, and Zambezia.

Training included the general themes of health, education, adolescence, and adolescent reproductive health. Trained teachers planned to replicate training in December 2004 in each of their provinces and support peer-to-peer education.

Senegal

Background

FGC continues in remote areas of Senegal even though the practice was outlawed in 1999. Advance Africa collaborated with the Senegalese chapter of FAWE which works within the formal educational system to combat FGC. Targeting young boys and girls at the elementary school level was a means by which to influence the future elimination of FGC. With its 113 centres of excellence across the country, FAWE had the capacity to reach many young children and promote the eradication of FGC through integration into the school curriculum of the harmful effects of FGC and the need to eradicate it.

Objective

The objective of the FAWE activity in Senegal was to contribute to the national objective of eradicating FGC. Specifically it was to:

- Train life and earth sciences instructors to provide FGC instruction in six regions during the 2003-2004 school year
- Raise students' awareness on abandoning the practice of FGC
- Begin cultural activities that advocate for prevention and abandonment of FGC within secondary schools of the six target regions

Activities

To accomplish the objectives there was a phased approach to the intervention.

<u>Advocacy</u>

The advocacy skills of FAWE members were used to integrate FGC prevention instruction into formal education sector. FAWE assisted in publicizing the law on FGC and organized public cultural activities designed to inform and raise awareness on the dangers of the practice.

Reference Manual and Tools Development
A reference manual containing facts and information of FGC was developed for trainers and teachers. A fact sheet on FGC was developed as a tool to be used by teachers and trainers in schools and in FAWE centers of excellence to conduct prevention activities.

National Curriculum development
Advance Africa and FAWE developed a national curriculum that integrated prevention of FGC instruction into formal school curriculum. The curriculum was validated through discussion groups and advisory sessions. The curriculum was planned to be used to scale up the effort beyond the six regions.

Trainings
A national TOT and six regional workshops were subsequently held using the curriculum. A core of 25 national trainers facilitated the regional trainings. As a result over 200 teachers were trained on FGC prevention and eradication. The trainings were supplemented by community cultural activities aimed at orienting community leaders and parents.

Results

As a result of the various FGC components, a corps of national trainers is in place to scale up the initiative in other regions. A toolkit for advocacy and training was developed. A national training curriculum, reference manual and supervision tool are in place to be used.

Capacity was built among teachers, centers of excellence coordinators, and community leaders to effectively act as champions and articulate the need for FGC eradication.

Inter-sectoral collaboration between the Ministries of Education and Health and FAWE was used in implementation, monitoring and supervision. Over 32,000 students have benefited from information on FGC prevention and eradication from the over 200 teachers acting as trainers.

Zimbabwe

Background

Since 1998, FAWEZI has been committed to creating positive societal attitudes that reinforce and influence educational policies and practices in order to promote gender equity at the district, provincial, and national levels through advocacy, lobbying, and networking with other stakeholders.

Since FAWEZI's launch, the organization has focused primarily on establishing its structures within the ten provinces in the country (i.e., Harare, Manicaland, Mashonaland Central, Mashonaland East, Mashonaland West, Bulawayo, Masvingo, Matebeleland North,

Matebeleland South, and Midlands). The demarcation of the provinces is based on the criteria used by the Ministry of Education, Sport and Culture. Each province has, on average, seven districts where FAWEZI is represented.

Advance Africa worked with FAWEZI in each province to increase the awareness of ARH among adolescents and provide them with life skills as they approach adulthood.

Activities

Training of Trainers (TOT)
Teachers and peer educators in the various provinces and districts participated in the TOTs, which were conducted by national trainers from FAWEZI and an Advance Africa ASRH training consultant.

The Training of Trainers covered the core modules contained in the *Integrating ASRH into FAWE Programmes Curriculum*:

- An Introduction to Adolescent Sexual and Reproductive Health
- Adolescent Issues
- Life Skills Development
- Strategies for Developing Adolescent Friendly Reproductive Health Services
- Training of Trainers

The Training of Trainers module was conducted in the first two TOTs and omitted from cascade trainings to allow for additional ARH sessions. A new session, Adolescent Counseling and Group Talks, was added to the program to further equip teachers with how the delivery of ASRH friendly services.

Adolescent Issues consumed a fair portion of the program. This module focused on adolescent growth and development, sexuality, adolescent pregnancies, and STIs/HIV/AIDS. The sessions were co-taught and accompanied with videos and handouts on each topic.

Results

Table 7. LSE Training in Zimbabwe

Province	**Cadre/Course**	**Numbers Trained**	
		Expected	**Actual**
Mash West, Mash Central, Masvingo, Midlands	ASRH Training for FAWEZI and teachers from OVC sites	16	13
Mash Central, Mash East, Mat North, Mat South, Bulawayo	ASRH Training for FAWEZI teachers	18	17
Gweru Urban District Teachers	ASRH Training	14	14
Chinhoyi Urban & Zvimba district	ASRH Training for FAWEZI teachers	20	14
TOTAL		**68**	**58**

C. Lessons Learned

The experience in the implementation of the FAWE Senegal programme on FGC has showed clearly the importance of using local organizations with clout to influence policy and decision making. It has also demonstrated the building of a sustainable program.

The lesson in Zimbabwe is that without a guarantee of follow-up funding, programs initiated may not continue. It is, therefore, essential to determine a sustainable funding mechanism to ensure continuity of programs following termination of projects.

D. Conclusion

The implementation of LSE for adolescents as a strategy for repositioning family planning posed many challenges. There was a lot of skeptism about the feasibility of the program, however, at the end of the project, it was shown clearly that the right approach created the possibility to introduce FP/RH information and services for adolescents. The process is long and requires strong follow-up to ensure that the initial gains are consolidated. Community involvement was key to the success of the program in all countries.

3. Integration of Family Planning with Conservation Programs Advance Africa/Jane Goodall Institute Collaboration

A. Introduction

In support of IR1.3 "*Improved inter sectoral collaboration, linkages and integration of FP/RH services with health and non-health programs,"* Advance Africa worked in collaboration with the Jane Goodall Institute (JGI) to integrate family planning with environmental conservation. JGI received core funding for the implementation of a conservation program along the Congo River basin in DR Congo. Advance Africa was selected as the service delivery project to offer TA for the integration of FP/RH with special emphasis on family planning into their activities. This approach resulted from JGI's experience in a similar project implemented in Tanzania.

A joint proposal was developed for the project which was implemented in two phases. The first phase covered the development of the proposal, an evaluation of the Lake Tanganyika Catchment Reforestation and Education (TACARE) Project, which was a similar project implemented in Tanzania, and the field assessment which culminated in the development of an implementation plan.

The second phase was the real implementation of activities as well as monitoring and evaluation.

B. Activities

i. Evaluation of TACARE Project, Tanzania

The TACARE Project, a conservation project in the Lake Tanganyika area of Tanzania, was implemented by Jane Goodall Institute (JGI) between 1994 and 2003. TACARE added a family planning component in 1999. The external evaluation funded by USAID/Washington intended to document implementation and key lessons learned during the implementation. The model and lessons were to be used as a basis for the design of a similar project in DR Congo.

An evaluation field visit was undertaken in 2003 to Dar es Salaam and Kigoma in Tanzania. Advance Africa's Senior Technical Advisor for RH Clinical Services was included in the evaluation team. Prior to the field visit, there was a literature review related to the project as well as the initial development of the proposal for DRC that guided the content of the field interviews.

The evaluation described the intervention as *"a model for initiating community interest in improving their local environment as a means of contributing to a long-term conservation goals."* It raised a number of key lessons for the development of the project in DR Congo. Some specific lessons include the following:

1. Communities should be approached with non-conservation-related activities to build trust and gain acceptance, but the primary conservation objective should not be lost in the process.

2. Leadership from both the project as well as the community is critical to the success of implementation. Investment in leadership capacity may be needed as an initial investment in the community.

3. Baseline data is critical to measuring success (or lack thereof).

4. A critical mass of CBDs and supervisors is required if any significant impact is to be made. However, selection must be carefully conducted to ensure that the appropriate people are selected. For instance, in Kiziba, the CBDs selected were relatives of the village chair person and ward executive officer. They were not necessarily interested in the role and were expecting benefits. As a result, these CBDs dropped out after only a few months.

5. There is a limit to volunteerism on the part of CBDs, so incentives should be explored. Attrition was noticed in some villages such as Mgaraganza that started with 4 trained CBDs in 1999 but were left with only 1 by 2002. In Kiziba, all 4 trained CBDs dropped out by the end of 2002. Overall, out of 80 CBDs trained, only 50 were still active in the program at the end of 2003. Similarly, 9 out of 12 trained supervisors were still active at the end of 2003.

6. Once trust has been established, it is important to follow through on deliverables. The project did not receive funding during 2003 to implement planned activities. Increases in

volunteers recruited and trained as well as refresher trainings were cancelled. The project was also unable to provide resources like boots and bicycles that it had promised for the trained CBDs. This affected morale significantly and could undermine the gains over time.

7. Attention to gender issues is crucial, especially in the recruitment of CBDs. This will ensure that male participation is enhanced especially where males are more comfortable with other males counseling them.

ii. Assessment of the Kahuzi Biega Landscape in DRC

Specific criteria were applied in the selection of the Kahuzi Biega Landscape as the most suitable area for the Advance Africa/JGI integrated family planning and conservation project in DRC.

In preparation for the design of the program, an assessment of threats, opportunities, and approaches was undertaken for successful implementation. Advance Africa recruited a consultant who looked assessed the reproductive health availability with a focus on identifying opportunities, strengths, weaknesses, and threats to be considered for program implementation. The summary of key findings from the assessment follows.

The assessment covered Kasugho (TAYNA gorilla reserve), Walikale (gorilla reserve for Utundu), and Wassa and Butembo (adjacent to Maiko Park).

Discussions were centered around access to services, demand for services where they exist, and their quality. Where services do not exist, discussions focused on the way in which services can be effectively provided. Efforts were also made to elicit weaknesses and threats as well as opportunities and strengths for effective RH/FP service delivery.

A key observation was that even though all respondents were aware of the importance of RH/FP, they conceded that RH/FP services were not functional except for antenatal services among a limited target group.

Other observations include:

- There was a very receptive political authority that was keen on ensuring the introduction of FP services
- Availability of prenatal services in all health centers and posts was another opportunity to build on in the establishment of FP services
- Community organizations are critical in the delivery of RH/FP services and can play a critical role in the establishment of a community based distribution and referral system
- The MOH Reproductive Health Unit documents a number of useful events that can form a foundation in measuring the success of RH/FP service introduction in the target area

The key constraints that were considered in developing the program are the following:

- Existence of pockets of insecure areas

- Geographic inaccessibility of a large number of areas in the zone
- Extreme poverty of inhabitants
- High level of illiteracy
- Ignorance about family planning
- Absence of trained family planning service delivery personnel
- Negative influence of some religious leaders on family planning uptake
- Absence of community-based distributors (CBDs)
- Non-existence of organized post natal services
- Non-existence of family planning services

In spite of these constraints, there are a number of opportunities that can be taken advantage of to accomplish the provision of RH/FP in the zone. These include the following:

- Readiness of communities to accept family planning
- Presence of maternity homes, clinics, and hospital
- Antenatal services already being provided
- Presence of personnel already providing care and treatment
- Existence of appropriate infrastructure
- Presence of NGOs who are prepared to support CBD activities
- Readiness of community members to contribute financially to the service
- Presence in Butembo of an NGO that undertakes BCC in HIV/AIDS and family planning
- Readiness of community members to volunteer to become CBDs

The willingness of both the political leadership and the community members to embrace family planning will enable existing opportunities to easily overcome the constraints and threats. Service delivery personnel were prepared for training to provide family planning services. The MOH Reproductive Health Unit has a number of IEC materials that have recently been produced for education on the benefits of family planning that can be used in the target zone.

In the light of the key findings, the assessment found that family planning services could be implemented in the zone. CBDS were determined to be key providers in view of the difficulty in access to most of the communities in the zone. The existence of clinics and a hospital will serve as service delivery points to which referrals were made. NGOs already working in the area were allies in family planning sensitization.

For quality assurance and sustainability, the MOH Reproductive Health Unit is an asset committed to ensuring the success of extending family planning services to this area.

iii. Implementing the Family Planning/Conservation Integration Program

Objective: To provide quality family planning services to women and men of reproductive age in the Lubero Health Zone of Graueri Landscape in Eastern DRC.

Strategy

1. Community based distribution will be used to offer services as close to clients as possible
2. In addition, already existing health posts, clinics, and hospitals will be used as referral centers

iv. Activities

Start up activities included a review of existing IEC materials for suitability and dissemination in the sensitization of community members. A number of fliers and posters were approved by a team from the MOH Reproductive Health Unit, SANRU, and Advance Africa. Materials were reproduced and disseminated in the region's communities.

Discussions were held with the Lubero Zone Health Director for selection of nurses and other health workers for training in family planning. Similar discussions were held with community leaders to select individuals for training as CBDs.

Eventually 31 nurses and 32 CBDs were trained in November 2004. Contraceptives and contraceptive kits for CBDs were supplied to trainees. Although training was completed in November, service delivery commenced in March 2005.

C. Results

The initial result of contraceptive distribution from March to May 2005 is documented below.

Table 8. New acceptors of FP in the Lubero Health Zone Eastern, DR Congo, March – May 2005

Method	March	April	May
Depo Provera	54	37	54
Pills	62	92	65
IUD	9	11	15
Condoms	97	48	134
Tubal Ligation	26	8	12
LAM	43	47	22
Cycle beads	7	0	4
Total	298 (5%)*	243(4.1%)*	306(5.2%)*

*Estimated target population - 5860

The zone targeted 5% of the target population, 5,860 women of reproductive age, which was reached in March and May. It is still early to see the trend over time.

D. Lessons Learned

The family planning/conservation integration effort faced a number of challenges, key of which were the sporadic outbreaks of violence in the areas adjacent to the zone. These outbreaks

interfered with planned activities. Nevertheless, it was eventually possible to recommence service delivery. Key lessons learned included:

- The active participation of the MOH, both at the national and zonal levels, was crucial. Their involvement provided leverage and support that will ensure sustainability after project end.
- The project liaised closely with Union of Associations for the Conservation of Gorillas and Community Development (UGADEC) as a conservation partner and existing implementer. This created the credibility required to jump start the program.
- Close collaboration with SANRU ensured a more efficient use of resources with previously developed IEC materials with Advance Africa technical assistance.
- Lessons learned from the TACARE Project in Tanzania were valuable in designing the DRC integration program.

E. Conclusion

A crucial strategy in repositioning family planning is its integration with non-health programs. The experience in the Lubero health zone in integrating family planning into the Jane Goodall Institute conservation program has demonstrated that it is feasible to provide family planning as well as other reproductive health services as an integral part of a larger conservation activity. The RH/FP component indeed satisfies a felt need that enhances the acceptance of the conservation program. With the limited results that were obtained following program implementation, it is clear that a need is being met. Over time, it is expected that this will contribute to improving family planning uptake locally and nationally.

Lessons Learned and Recommendations

Advance Africa had a very rich experience integrating FP activities into health and non health sectors. In order for such integration to be a success it required a lot of flexibility, openness and strategic thinking. This integration used a multisectoral approach and was initiated within ongoing interventions that offered a real opportunity to make it happen. Thus, the integration occurred within existing HIV/AIDS activities either VCT centers or PMTCT programs, in education programs with FAWE chapters, and within the conservation of forest activities with the Jane Goodall Institute. The Advance Africa project basically used an opportunist strategy that focused on building coalitions and partnerships with different programs that resulted in a win-win relationship. With each partner, we highlighted the benefits that the new partnership brings to the program, both in terms of performance and in savings. Development of a set of systematic steps to follow and an appropriate coordination mechanism are essential to the success of this collaboration to integrant FP in health and non health activities.

Our main recommendations are:

- Consider any functional and effective intervention in any social sector as a potential opportunity for integration of FP activities.
- The integration must be done only where integrating activities makes sense.
- It is key that all Parties involved in all integration processes should perceive themselves as winners.

- On the programmatic side, it is important to systematize the coordination; constantly monitor progress and performance at all level of the process,; and favor the group decision making process.

ANNEX 1: EXECUTIVE SUMMARY

Analysis of Family Planning / HIV/AIDS Integration Activities within the USAID Population, Health and Nutrition Center

Results of a Survey Conducted by
Advance Africa and
The CATALYST Consortium

As HIV/AIDS becomes more prevalent in all parts of the world, it is imperative to explore innovative ways to prevent its further spread and to treat those who are already infected. One strategy that has come to light is the integration of HIV/AIDS and reproductive health services. If effective, this strategy will increase the availability of both HIV/AIDS and reproductive health services, potentially making all of these services more cost-effective and more holistic.

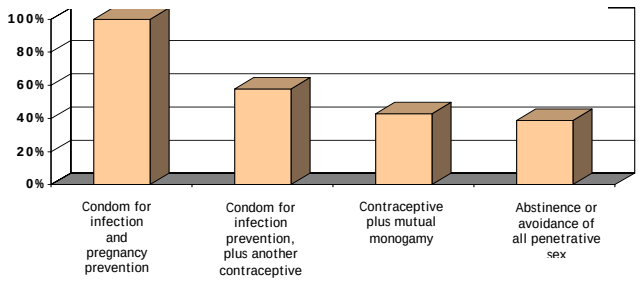
As a first step in determining the efficacy of this strategy, Population, Health and Nutrition Center (PHNC) of the U.S. Agency for International Aid (USAID) asked Advance Africa and the CATALYST Consortium to conduct a survey to identify what types of integration activities are already in place. Twenty-five agencies responded to the survey, which was conducted in late 2001.

Results of the survey show that USAID has invested well over $200 million in just four years. About half of this amount has been channeled through bilateral programs, one-third through field support, and 14% through core funding. Other donors to these 25 agencies have contributed $120 million over the four years. The agencies report 95 dual protection projects and 129 integration projects.

The majority of integration and dual protection projects are being implemented in Africa, the region most affected by HIV/AIDS. Many fewer are being implemented in Asia and the Near East and Europe and Eurasia, two regions where HIV infection rates are beginning to soar. As of spring 2002, most projects focused their work on communication, training, and education, with much less attention to strategies such as voluntary counseling and testing, prevention of mother-to-child transmission, and generating policy.

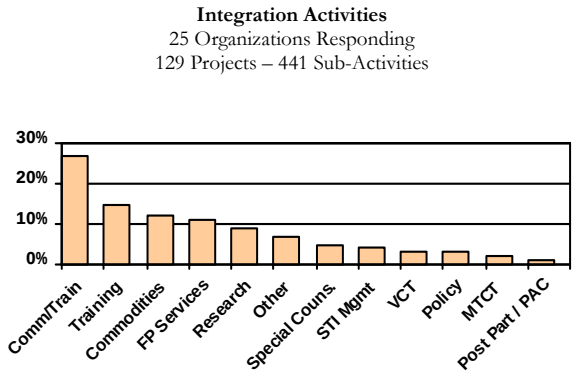
The focus of dual protection and integration projects thus far has been on working with general populations (family planning and maternal and child health clients, and their partners), rather than specific high-risk groups. Those projects that work with youth work about equally with in-school and out-of-school populations.

Dual Protection Strategies Used
25 Organizations Responding
95 Projects



Dual protection projects unanimously promote the use of condoms for both infection prevention and pregnancy prevention. Fewer of these projects promote other dual protection strategies such as condoms plus another contraceptive, mutual monogamy, or

abstinence. Over the four years covered by the survey, the 25 responding agencies distributed over 1.8 billion condoms for dual protection, very few of which are female condoms.



Integration projects are heavily influenced by the work of Population Services International (PSI), which implements almost half of the reported integration activities. Projects use about equally the two integration strategies: integration of HIV into existing family planning services, and integration of family planning into existing HIV services. When PSI is excluded from this calculation, however, the majority of the projects integrate HIV into existing family planning services. Most of the integration projects are community-based and focus on communications and training, commodities and services.

Almost three-quarters of the dual protection and integration projects use monitoring and evaluation systems. The data collected with these systems focus mainly on knowledge, attitudes, and practices, and somewhat less on capacity and sustainability.

The 25 organizations report that institutional factors (personnel issues and lack of materials) are among the major barriers to the success of dual protection and integration projects, followed closely by community, cultural, and religious factors. Factors that enable the success of these projects are mainly related to commitment, collaboration, and stakeholder involvement, along with service provision.

Although it was not within the scope of this survey to assess the efficacy of integration as a strategy for combating HIV/AIDS, the results can be used as a basis for such investigation in the future. The survey can also be shared with other donors and be used for collaborative planning to address the global spread of HIV/AIDS.

For further information or for the complete survey report, please contact Nina Pruyn at Advance Africa, npruyn@advanceafrica.org or 703-310-3500.